

# 2010 Annual Information Form

**This information will be used for all programs during 2010. Please attach a separate page with other pertinent information if needed.  
Please contact the SRACLC office if any information changes throughout the year.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  Male  Female Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**\*Please list Primary (P) and Secondary (S), check others if applicable.**

- |  |  |
|--|--|
| Attention Deficit Disorder (ADD) ..... | Emotional Delay (ED) .....                           |
| Autism (A) .....                       | Learning Disorder (LD) .....                         |
| Behavior Disorder (BD) .....           | Multiply Challenged (MC) .....                       |
| Brain Injury (BI) .....                | Physically Challenged (PC) .....                     |
| Deaf/Hard of Hearing (D/HH) .....      | are orthopedic devices worn? Yes / No                |
| Developmental Disability (DD) .....    | can transfer into van seat or stadium seat? Yes / No |
| Down Syndrome (DS) .....               | Severe Mental Handicap (SMH) .....                   |
| Early Childhood (EC) .....             | Trainable Mental Handicap (TMH) .....                |
| Educable Mental Handicap (EMH) .....   | Visually Impaired (VI) .....                         |
|  | Other (list).....                                    |

**If Down Syndrome**, has participant been tested for atlanto axial instability? Yes / No  
Does your participant have atlanto axial instability? Yes / No

**Medication** (this information needs to be updated each season or whenever dosage changes)

Does the participant receive any medication? Yes / No  
Will the participant be taking medication during programs? Yes / No

**\*\*\*If yes, you must complete the Medication Dispensing Information form and waiver.**

<u>Medication</u>	<u>Dosage</u>	<u>Time (s)</u>	<u>Purpose</u>

**Health Issues**

Does the participant seizure? Yes / No  
Types, signs & reaction \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the participant have allergies? Yes / No  
Types & reaction: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dietary Issues**

Does participant require assistance eating or drinking? Yes / No  
•have any food restrictions? Yes / No  
•have any food dislikes? Yes / No  
•have any specific food likes? Yes / No

Comments: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Comments: \_\_\_\_\_

**Behavior Issues**

Does participant display unusual fears? Yes / No  
•comply with verbal requests? Yes / No  
•respond to specific directions? Yes / No  
•have any known situations that set them off? Yes / No  
What actions are to be taken if a particular behavior is presented? \_\_\_\_\_

Comments: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Comments: \_\_\_\_\_

•respond to any reinforcement methods? Yes / No

Comments: \_\_\_\_\_

•respond to any behavior improvement techniques? Yes / No

Comments: \_\_\_\_\_

**Safety Issues**

Does participant need assistance orienting to:  
people place time  
Does participant need assistance protecting:  
self anticipate safety needs  
Does participant need assistance toileting:  
independent monitor diapering

**General Issues**

Does participant use: wheelchair stroller  
walker cane crutches  
If participant is non-verbal do they use:  
sign language communication board/book